New Jersey Department of Health and Senior Services
Division of Aging and Community Services

Home and Community-Based Programs
PLAN OF CARE

1. Participant Name	2. JACC/Medicaid No.	3. Case Manager Name/No.:
4. Consumer Directed: ☐Yes ☐No ☐N/A	**5. Care Plan Date**	**6. Re-Assessment Due:**

7. Program: ☐AL ☐AFC ☐CCPED ☐HCEP ☐CAP ☐JACC

Date	Need Code	Problem Statement	Service Needed	Desired Goal Code	Service Delivery Pattern		Provider Type	Provider	CEP ONLY: Special Requirement/ Qualification (Y/N, Specify)	Payment Source	Monitoring Method	Monitoring Frequency	Desired Goal Achieved (Y/N, Specify)	Date
					Units Per Visit	Frequency								
8	9	10	11	12	13	14	15	16	17	18	19	20	21	22

Signature of Participant	Date	Date	Signature of CM Supervisor	Date	Date
Signature of Case Manager	Date	Date	Other (Specify):	Date	Date
Signature of Facility Representative	Date	Date	Other (Specify):	Date	Date

Need Codes: (Item 9)
Client Unable to:
1. Perform ADL
   ADLs: (use with Need Code #1)
   a. Bathing/personal hygiene
   b. Dressing
   c. Toileting
   d. Transferring
   e. Continence
   f. Eating/Nutrition
   g. Mobility
2. Perform IADL
   IADLs: (use with Need Code #2)
   a. Meal Preparation
   b. Shopping
   c. Managing Money
   d. Housework
   e. Arranging Appointments
   f. Laundry
   g. Taking Medication
   h. Transportation
   i. Mobility outside the home
3. Needs Medical Attention
4. Client is Socially Isolated
5. Home Environment is Unsafe/Unclean
6. Safety Supervision
7. Communication Needs
8. Other

Desired Goal Code: (Item 12)
1. Maintenance
2. Independence
3. Rehabilitation
4. Prevention
5. Resolved
6. Other:

Frequency: (Item 14)
D - Daily
Specific days - M,T,W,Th,F,S,Su
WK - Weekly
B - Bi-weekly
MO - Monthly
Q - Quarterly
A - Annually
O - Other (Specify):

Provider Type: (Item 15)
C - (CEP) Client Employed Provider
F/P - Facility/Program
I - Informal Support
N - Non-Traditional Service
T - Traditional Medicaid Enrolled
FS - Formal Support

Payment Source: (Item 18)
1. Medicaid
2. Medicare
3. Other Third Party Liability (TPL)
4. Local Community
5. Other Public Funding
6. JACC
7. Informal Support
8. Formal Support - Fee
9. Formal Support - No Fee
10. Other:

Monitoring Method: (Item 19)
C - Client Report
S - On-site review
R - Receipts
D - Documentation (Specify):
T - Tel. Contact with
O - Other:

Monitoring Frequency: (Item 20)
D - Daily
W - Weekly
B - Biweekly
M - Monthly
Q – Quarterly
A – Annually
R - Random
U - Upon reported completion
O - Other

Home and Community Based Programs
PLAN OF CARE (Continued)

Need Code 9	**Reason Need Unmet 23:** 1. Not available 2. Not affordable 3. Waiting list 4. Frequency not adequate 5. Refused 6. Other (Specify) - Expound on reason if necessary	**24. Special Notes or Comments** (Include the date and initial each entry)

LONG TERM CARE ASSESSMENT		
25. Health Status:	26. Social Support Network:	27. Physical Environment:

Completions of sections 25-27 certifies that I have reviewed the New Jersey EASE Comprehensive Assessment Instrument on the above recipient, and nursing facility services, as defined by the New Jersey Medicaid regulations, continue to be required.

Care Manager Signature	Date	Case Management Supervisor	Date
		Registered Nurse Co-Signature (If Required)	Date